MAP-612
(8/06)

KENTUCKY MEDICAID PROGRAM
STATEMENT OF AUTHORIZATION FOR PAYMENT

I hereby declare that I _____
PHYSICIAN ASSISTANT NAME

_____, _____
PA MEDICAID NUMBER NPI (NATIONAL PROVIDER IDENTIFIER) NUMBER

a licensed PHYSICIAN ASSISTANT, have entered into a contractual agreement with the following:

_____, _____
SUPERVISING PHYSICIAN NAME SUPERVISING PHYSICIAN NUMBER

_____
SUPERVISING PHYSICIAN ADDRESS, CITY, STATE, ZIP

to provide professional services.

As part of our contractual agreement, I understand that the physician listed above shall be responsible for submitting claims and refunding any overpayments made for services rendered.

_____ _____
SIGNATURE OF PA PA SOCIAL SECURITY NUMBER

_____ _____
INDIVIDUAL MEDICARE NUMBER DATE PA SIGNED

_____ _____
PA LICENSE NUMBER DATE CONTRACT EFFECTIVE

_____ _____
SUPERVISING PHYSICIAN SIGNATURE DATE SUPERVISING PHYSICIAN SIGNED

PLEASE RETURN FORM TO:
KY Medicaid Provider Enrollment
P.O. Box 2110
Frankfort, KY 40602-2110